PHILADELPHIA NEUROLOGICAL SOCIETY.

January 23, 1899.

The President, Dr. F. X. Dercum, in the chair.

Dr. F. A. Packard read a paper with the title "Acute Anterior Poliomyelitis Occurring Simultaneously in a Brother and Sister." (See p. 210.)

Dr. Charles K. Mills said that in recent years he had come to the conclusion that anterior poliomyelitis is an infectious disease, but that he had very little experience with its occurrence in members of the same family. The fact that the disease frequently occurs in healthy children with a good family history would seem to lend strength to the view that it is of infectious origin.

Dr. Charles W. Burr remarked that a disease occurs in pigs which probably is an anterior poliomyelitis. The disease begins with slight fever, the animal appears to be sick, then it becomes palsied, and later the muscles waste. He knew nothing as to the condition of the reflexes. Sometimes the hind legs are affected, sometimes four legs and sometimes three. Sensory symptoms seem to be absent. If the pig is pinched, it squeals. Sometimes all the pigs in a pen are affected, sometimes only one is attacked. This disease is certainly infectious and he thought that it was the same as that which occurs in children.

Dr. F. X. Dercum presented a case of chronic poliomyelitis of the adult, affecting the entire cord and involving also the medulla.

The patient was a farmer, 69 years of age, who one year previously had noticed occasional huskiness in his voice. This huskiness had gradually increased and finally led to an examination of the throat by a laryngologist, who stated that the patient presented a paresis of the vocal cords. The patient was then referred to the nervous clinic of the Jefferson Hospital on December 12, 1898. The symptoms of bulbar palsy were at once noted. Phonation was extremely difficult. There was marked paralysis with atrophy of the tongue and marked inability to move the lips, especially to imitate the movements of pouting.

On stripping the patient, marked muscular wasting was found in the arms and legs of both sides and also in the trunk. The atrophy was most marked in the muscles of the shoulder girdle: the deltoids and supraspinatus and infraspinatus muscles showing the greatest degree of change. Fibrillary tremors were widely diffused and noticeable not only in the muscles in which atrophy had become pronounced but also in numerous other groups. Distinct atrophy was also present in the gluteal regions, thighs and legs. Fibrillary tremors were also noted in these situations. The knee-jerks and elbow-jerks were distinctly minus. No sensory phenomena were observed, nor were there any ocular manifestations.

Dr. Dercum stated that in his experience cases of poliomyelitis in the adult, so extensively diffused, were comparatively rare. The more common syndrome observed is that in which atrophy is first manifested in the hands, in the thenar and hypothenar eminences, and as the case progresses, spastic symptoms make their appearance in the legs; the legs not showing atrophy as do the arms, but on the contrary presenting more or less rigidity with exaggeration of the knee-jerks. In other words the syndrome of amyotrophic lateral sclerosis, with or without involvement of the medulla, is the more common form of muscular atrophy of spinal origin in the adult.

Dr. Dercum also placed on record a case of organic hemiplegia with hemianesthesia, extending over five years.

J. B., male, aged 49; a mulatto; an inmate of the wards of the Philadelphia Hospital, had suffered from an apoplectic seizure five years ago, the attack being followed by hemiplegia of the left arm and leg, together with a sharply defined and persistent hemianesthesia of the same side. The man presents to-day signs of a spastic hemiplegia of the left side, moderate in severity, together with a moderate degree of contracture of the left arm and spastic rigidity and exaggeration of the knee-jerk of the left leg. The hemianesthesia at present is sharply delimited by the middle line of the body and appears to be everywhere complete. A right sided homonymous hemianopsia is associated with this hemianesthesia. There is no impairment of hearing upon the left side nor is there any involvement of taste or smell. The sensory symptoms are limited to those concerned in the various forms of cutaneous sensibility and the visual phenomena just stated. There can be no doubt that in the present instance the lesion was so situated as to involve not only the fibers of the anterior two-thirds of the posterior limb of the internal capsule, but also the posterior third of the posterior limb and the fibers of the optic radiations. Cases of hemiplegia, even of organic origin, with *persistent* hemianesthesia are in the experience of Dr. Dercum comparatively rare. Hemianesthesia and hemianopsia are not infrequently observed during an apoplectic seizure, or immediately subsequent to a seizure, but it is quite common for these symptoms to disappear at a relatively early period, and they are therefore to be regarded as distance symptoms. Actual lesions of the posterior portion of the internal capsule and of the optic radiations must be a rather rare occurrence.

Dr. W. G. Spiller spoke of the recent views regarding the location of the sensory fibers. It had been believed that the external bundle of the peduncle was sensory, because it did not degenerate downward after lesions of the inner capsule. Dejerine had shown by several cases that this view was incorrect, and that this bundle of fibers has its origin in the second and third temporal convolutions, and does degenerate downward if the lesion in the internal capsule extends downward sufficiently to cut these fibers. Mills and Spiller had confirmed the observations of Dejerine, to the extent of showing that the external bundle of the cerebral peduncle does not arise in the first temporal convolution, and Spiller had published the report of another case establishing the same fact. The case of Mills and Spiller was one of abscess in the first temporal convolution with absence of all degeneration in the external bundle of the peduncle by Marchi's method. The case of Spiller was one of infantile hemiplegia of many years duration, with destruction of the first temporal convolution and integrity of the external bundle of the peduncle.

Dr. Spiller referred to the views of Dejerine regarding the absence of a distinct band of fibers for the conduction of general sensation in the area posterior to the posterior limb of the internal capsule. He stated that Dejerine and Long had observed two cases in which a lesion was found in the posterior limb of the internal capsule, the thalamus was intact and sensation, therefore, had not been altered.

Dr. Charles K. Mills thought that it was not unusual, although not common, to find persistent hemianesthesia with hemiplegia in organic cases. He had seen a number of such cases. One of these was a patient who had been under observation for many years in the Philadelphia Hospital. The case was interesting in that it presented hemiplegia and hemianesthesia without hemianopsia. The case however throws no positive light upon the part played by lesions of the internal capsule in the causation of hemianesthesia, as the lesion involved both the thalamus and the posterior part of the internal capsule. The anesthesia was probably due to the lesion of the thalamus. He thought it probable that in Dr. Dercum's case a lesion involved both the posterior part of the capsule and the thalamus, and that perhaps the hemiplegia was due to the lesion of the capsule and the anesthesia to the lesion of the thalamus. He thought that the question of the passage of sensory fibers through the posterior extremity of the posterior limb of the internal capsule was not yet settled, as some physiological and pathological observations seemed to support the older view of the sensory functions of a portion of the capsule.

A CASE OF ANOMALOUS DYSTROPHY.

Dr. S. Solis Cohen presented a woman, 48 years of age, with a peculiar enlargement of the hands and feet. The menopause had occurred 6 years ago. The hands had always been rather large, but during the past three months they had steadily increased in size, and at the time the patient was presented were much larger than they had been a year ago. They were broadened and deflected to the ulnar side, and the fingers presented a conical outline rather than the sausage-shape of acromegaly. The feet had also increased in size. Skiagraphs showed that the enlargement of the hands was due to hypertrophy of the soft tissues, and not of bone. Some wasting was noticed in the first interosseous space. The nails were normal. The grip of the hands was weak. The forearms were normal, but pads apparently of fat were found on the arms. Paresthesia was felt in the hands and feet only during wet weather.

The feet were symmetrically enlarged, except that the increase of size was more noticeable over the malleoli. The enlargement was confined to the soft tissues.

The patellar reflex was much exaggerated, but ankle-clonus was not obtained. All forms of sensation were normal. Slight kyphosis was observed in the cervical region. Headache was not constant. The bones of the face were not enlarged. Over the lower jaw was a freely movable fatty mass giving a pointed appearance to the chin. Hemianopsia was not observed .

Dr. Guy Hinsdale agreed with Dr. Burr and Dr. Cohen that the case did not present the physiognomy of acromegaly. The absence of enlarged and prognathous jaw, the character of the fields of vision, the absence of exophthalmos, the absence of disease of the thyroid, the absence of history of disturbance of the menstrual function and the appearance shown by the skiagraphs would indicate a disease not related to acromegaly. He thought that the history of two attacks of typhoid fever was of interest as it is well known that the toxins produced in typhoid fever may cause remarkable changes in nutrition. Possibly this might prove to be the ultimate cause of the trophic changes in the extremities.

Dr. A. A. Eshner referred to the possibility of this being some form of adiposis or lipomatosis. As the skiagraphs showed and as physical examination indicated, the changes were confined to the soft tissues. It seemed to him that there might be a series of dystrophies with myxedema and cretinism at the one end and, perhaps, acromegaly at the other, not necessarily related. Whether or not simple obesity is related to this group of diseases is of interest. With regard to the apparent condition of the thyroid, he did not consider that a matter of much importance, for it is possible for the thyroid to be outwardly and grossly normal, while its function is seriously deranged.

Dr. David Riesman was reminded by this case of one reported recently by Lunz—the case of a woman with syringomyelia, who had marked enlargement of the right upper extremity, and a hand much like those of Dr. Cohen's patient. Lunz, following Marie, called the hypertrophy cheiromegaly. Dr. Riesman believed Schlesinger had reported a similar condition in syringomyelia under the name of macrosomia. He was unable to say whether Lunz's case threw any light on the case of Dr. Cohen.

Dr. William G. Spiller said that distinct atrophy of certain of the interossei muscles in one of the patient's hands had been noticed. Muscular atrophy is common in joint disease, and Dr. Cohen had obtained crepitation in some of the joints of the hand. It had occurred to Dr. Spiller that perhaps the hands in this patient corresponded to some extent to the *main succulent* described by Marinesco as pathognomonic of syringomyelia. Several cases have shown that this condition is not pathognomonic of syringomyelia and that it may be found in other diseases.

Dr. Wharton Sinkler thought that the hands of this patient were strikingly like the hands of a patient at the Philadelphia Hospital who had syringomyelia. The question arises, however, can we conceive of syringomyelia without any sensory changes whatever.

Dr. Spiller remarked that a case of syringomyelia without sensory disturbance and with necropsy had been reported by Dejerine and Thomas.

Drs. Musser and Sailer reported 8 cases of meralgia paræsthetica; 4 in males and 4 in females. The apparent causes of the condition were: pressure of an army belt followed by severe infectious disease; a neuropathic tendency, with history of a similar condition in the grandfather; neurasthenia; pregnancy in 2 cases; influenza; and vesicular eczema. One of the cases occurred in a woman suffering from neurasthenia who seemed to be worse during the menstrual period.

64. POLYNÉVRITE OURLIENNE AU COURS DE LA GROSSESSE (Multiple Neuritis from Mumps Occurring During Pregnancy). Louis Gallavardin (Lyon Médical, 89, 1898, p. 97).

Paralysis occurring in the course of or following mumps may be divided into three categories:

1. Facial paralysis caused by the direct invasion of the facial trunk by the parotitis.
2. Paralysis of central origin, cerebral or meningeal, of which Lannois and Lemoine have reported four examples. To these Glénerau and Liégeois have each added one case.
3. Paralysis due to peripheral neuritis such as may be caused by any infectious disease. It is an example of this last class that the author reports.

A woman of thirty years, seven and a half months pregnant, was perfectly well up to three weeks before admission to hospital when she was taken with mumps affecting both parotids. The swelling of these glands had disappeared at the end of a week when she began to suffer from pruritis of the entire body, but especially of the extremities, which lasted four or five days and was succeeded by pains in arms and legs. Soon thereafter general weakness made its appearance and increased until she was bedfast.

Examination revealed paresis, almost amounting to paralysis, affecting the entire body, loss of muscular sense and diminution of cutaneous sensibility increasing from the trunk towards the ends of the extremities. Knee-jerk and plantar reflex were abolished, the sphincters unaffected and mentality normal.

The patient grew worse for the next two weeks when labor came on and she was delivered of a living child, at the end of the eighth month. After the confinement, improvement was gradual, but practically continuous, and two months later muscular power was very good, but co-ordination was so bad that she was absolutely unable to walk. Nearly three months later there still remained marked ataxia of arms and legs and the knee-jerks were absent. PATRICK.